Presidential Address
September 2016

Debra, thank you for this and not picking the more unflattering photos my daughters chose to send you!

What a privilege and pleasure it has been to be your President for the last year. I have had the opportunity to travel from one end of the country to the other and talk with General Surgeons from virtually every province. I also had the chance to meet with Health Ministers accompanied by CAGS provincial representatives which was a singular honour. This was an opportunity for General Surgeons to tell our story and underscore the value that we provide to the population of Canada.

Before I focus on the theme of my Presidency – Advocacy, I would like to recount the story of CAGS and General Surgery.
Next year CAGS will be 40 years old. 1977, the year of its incorporation, was a very memorable year.

- The first Apple computer went on sale,
- Jimmy Carter succeeded Gerald Ford as 39th US President
- The Toronto Blue Jays played their 1st game against the Chicago White Sox
- Concorde commenced its air service between London and New York

- US inflation was 6.5%, (15.8% in the UK) 1L gas cost 65 cents
- The World Trade Centre was completed
- Elvis Presley died – though some would say “allegedly”
- For you Eonophiles, it was the worst year ever for Bordeaux wines but great for Port
- This too was the year I graduated from Medical school. So allow me to draw a picture for you of who and what is CAGS

CAGS has 2300 members, a quarter of whoM are residents. I am delighted to tell you that we have XXXX attendees here at CSF (our largest ever attendance). Half of all General Surgeons work in centres populations of with greater than 500,000 while only 13% work with populations with less than 50,000. 60% of General Surgeons complain they do not have enough access to endoscopy resources, a third complained of inadequate OR time but, somewhat to my surprise, only a quarter said that they do too much call!

While this audience hardly needs reminding, this is very much preaching to the choir, as Adam Meneghetti, Program Director, University of British Columbia, pointed out, following my recent presentation in Vancouver. However, I personally believe that any and all opportunities to flag wave for General Surgery is an important mission for us all.

Ask your non medical friends, family members and Ministers of Health what a General Surgeon does – blank stares are the norm. Not I think true when the same people are asked what a plastic surgeon, neuro surgeon or an orthopedic surgeon does day to day.

So to quote the ancient Greek Aphorism “Know Thyself” – a moment to review who we are and what we do seems opportune.

We do 70% of all cancer surgery, and manage 95% of all major traumas. More over 50% of all endoscopies are performed by General Surgeons nationally, but this rises to a staggering 90% in the community. Virtually every single appendectomy, cholecystectomy, abdominal wall hernia, bariatric procedures are all done by General Surgery. All (non gynecologic) abdominal catastrophes ie - peritonitis, bowel obstruction, bowel perforation, open abdomens etc all done by General Surgery.

Never let it be forgotten, without a Division of General Surgery there can be no medical school. Every single medical student, surgical resident and many non surgical residents are all taught and trained by General Surgeons.

Without General Surgery a Hospital simply can not call itself an Acute Care Facility.

So does General Surgery have an image problem? Probably we tend to define ourselves by our area of interest or subspecialty – colorectal surgery, HPB, surgical oncology etc but this separation tends to divide us, - not unify us around the peritoneal cavity, teaching, on-call or medical leadership.

Many say that the problem is one of the name – General "so you aren't really a specialist!" Yet when we asked CAGS membership, half said don't change the name. (Of course, that means the other half would like a name change) Imagine the debacle if we tried. Look what has happened as a consequence of the very close Brexit vote in Britain!

And so to advocacy. This is the political process, by an individual or group, which aims to influence decisions within political, economic, social systems and institutions. When surveyed, 95% of CAGS membership said that advocacy was important. However, only 16% felt that CAGS was doing a good job of advocacy, hence the theme of my Presidency. However, fearing that we would get too many suggestions we didn't actually ask "advocate for what?!" This response did, however, give your Executive pause – unlike our friends at the American College of Surgeons, who have 20 full-time staff in their Washington office, dedicated to advocacy, we in CAGS have none! To be fair, much of the American College's advocacy is expended on fee codes. Our provincial structure, of Medical Associations negotiating with provincial governments, is not an area where a national organization such as CAGS should interfere.

So what does make advocacy effective? Well it certainly isn't going to be political decision makers and budget holders complaining that we aren't adequately compensated or that it is unfair that one group gets more than we do for the same type of work, however unfair that reality is. It certainly isn't any suggestion that General Surgeons are "hard done by" given our average national earnings makes us look entirely self-serving. Our message must be to demonstrate the real value that we provide to the people of Canada. But, certainly there are lessons we can learn from the American College of Surgeons Advocacy engine. First and foremost – US advocacy is a legislative matter with the ultimate aim to get a Bill passed through senate and congress – this is not the Canadian approach. Provincial issues such as a new trauma program or bariatric centre are primarily health authority related and rarely get in front of the house. Relationship building is the key. In the US this means with legislators; in Canada, with provincial and federal politicians. A very powerful line that resonated with me when I attended the American College of Surgeons Advocacy meeting, which was loudly stated – "the opposite of anecdote is data" There are 3 H's when talking with politicians; Head, Heart and Health – what this means in practice is that we must provide personal stories (of patients). Make issues local, personal, urgent and interesting – do not provide a mountain of statistics. It has been my personal experience decision makers will always ask for the data, but in truth their view is "don't confuse me with the facts my mind is made-up!"

At the meeting with decision makers it needs to be organized into 3 components:

1. The Hook ie the introduction
2. The line ie the patient
3. The sinker – the ask

So does CAGS have priority issues of National concern? – Well I believe we do and in my view these are:

1. Endoscopy
2. Rural and Remote Surgical Care
3. Acute Surgical Care
4. Human Health Resource Planning

I would like to take a moment to briefly review these:

1.2 million endoscopies are performed annually in Canada. As I mentioned previously, when done in the community 90% are performed by General Surgeons who spend one to two days a week in the Endo suite. CAGS's Endoscopy Committee comprising of Mark Walsh, Tony Gomes, David Pace and Jim Ellsmere as well as your CAGS Executive have been working closely with the Canadian Association of Gastroenterologists on a position statement on Endoscopy which is in the final stages of development. Additionally, a Memorandum of Understanding for the endoscopic skill enhancement program developed by Canadian Association of Gastroenterologists which Canadian Association of General Surgeons will partner with is about to be ratified. My counterpart, Dr. David Armstrong, President of Canadian Association of

Gastroenterologists and Endoscopy leaders of CAGS feel that the time is right for a National Endoscopy strategy similar to that which already exists in the UK and Australia. This strategy needs to be proposed to the Federal Minister of Health, the Honorable Jane Philpott.

Discussion around the delivery of surgical services in rural and remote locations continues to stir passions! Solutions provided are varied as the very landscape of the country itself. In Western Canada, spear headed by Peter Miles, Grand Prairie, Garth Warnock, Vancouver and Nadine Caron, Northern British Columbia in collaboration with the Rural Physician Committee they have proposed a highly structured, mentored and monitored system to upskill specifically identified family doctors in trauma care and a very narrow basket of acute care surgical procedures. In Ontario the model favoured by the likes of the Ontario Association of General Surgeons membership including Chris Vinden and Angus McIver would involve a coordinated, structured locum service sending committed surgeons to remote locations for varying lengths of time.

But make no mistake; both of these strategies would require considerable infrastructure and funding. The energy and enthusiasm so common amongst committed CAGS members require business plans and grant support that demand professional assistance.

In Eastern Canada, General Surgeons are required to provide services not typically taught in General Surgery residency programs. These include pace

maker insertion, amputation, and vascular access for renal transplantation as well as caesarian-section. Surely this is an opportunity for the Royal College's competence by design to focus program directors in population needs base training. A recently developed Position Statement on Rural Surgery has been endorsed by the CAGS Executive.

Rather than the "cost of doing business" Acute Care surgery is evolving into a major component of General Surgery. President elect, Morad Hameed, is championing the cause and I know will be spending much of his Presidency informing institutions and political leaders of the increasingly serious, onerous and ultimately costly burden that Acute Care Surgery demands.

Intimately coupled to Acute Care Surgery is the coming Silver Tsunami. In 2011 16% of the population was over 65 years of age. It is estimated that by 2031 it will be 28%. While much discussion is about long-term care and bed availability, General Surgery will inevitably be at the "pointy end" – the 78 year old obese, diabetic, COPD patients, previous CABG presenting with perforated diverticulitis needing an emergency laporotomy, colectomy, ostomy, post operative ICU and three weeks hospital stay is going to be ever more common. Rachel Kadaroo and her team at the University of Alberta are actively exploring best practices for managing seniors with this type of burgeoning population health problem will only get worse as those of us in that Baby Boomer group demands ever more health care resources.

This segues nicely into our own future –residents – as previously mentioned represent a quarter of our members. Matt Strickland, University of Toronto, Gurpal Johal, University of British Columbia and Gabrielle Gauvin, Queen's University of the CAGS Resident Committee have been doing Yeoman's work (not just in designing CAGS OR caps, please purchase) but in the area of resident employment. There is an increasing recognition at the Royal College and provincial government levels that we have been woefully inadequate in understanding the physician and specifically General Surgery labour market. The supply / demand economics and nudge / wink approach to achieve a consultant position is not going to be the solution for very much longer, similarly doing more fellowships can not be seen as the answer to finding a job. The subject is made more complex by the oft expressed concern that residents aren't as well trained as we were – however 3,000 years ago the Socrates expressed similar concerns about the inexperience and inadequate training of youths!. Of course, reduced call hours, skills miss matched, lack of mandatory retirement, and absence of transitioning out of practice strategies are frequently highlighted as causes of this problem. CAGS, for its part, is developing a searchable data-base that at the very least, will identify where General Surgeons are working and how long they have had their FRSC, which will allow prospective job seekers to focus their interests and intentions and target particular institutions.

In my final few moments on stage here I hope you will indulge me in some crystal ball gazing. With CAGS approaching its 40th birthday I think I can confidently state that the next 40 yrs of General Surgery in Canada is going to be very exciting. We will certainly respond to the reality of diseases coming and going, much like peptic ulcer disease, which was an epidemic in the late 70's and early 80's -- as a trainee I was involved in up to 5 PUD surgeries a day. With targeted and individualized therapy, will breast cancer surgery become salvage only? With improved screening, will colon cancer no longer be the 2nd commonest malignancy? Will the epidemic of obesity be "cured" in the future with a vaccination – only time will tell?

Whatever the realities of the medical landscape, I believe CAGS will continue to flourish and become ubiquitous for every General Surgeon in Canada and even perhaps beyond.

Thank you to all attendees for making this the finest and best Canadian Surgery Forum ever.